UPDATED INFORMATION

Medi-Cal Bulletin **Updated January 5, 2007**

Pharmacy

California Department of Health Services
Emergency Drug Benefit for the Dual Eligible

In order to ensure that people who are dually eligible for Medicare and Medi-Cal continue to get needed medications, the California Legislature has enacted and Governor Arnold Schwarzenegger has signed Assembly Bill (AB) 813 that establishes an Emergency Drug Benefit (EDB) program for individuals dually eligible for Medicare and Medi-Cal. AB 813 allows the California Department of Health Services (CDHS) to continue covering the cost of medications for dual eligibles who are unable to obtain their medications from the Medicare Part D program for dates of service from May 17, 2006 through January 31, 2007.

The EDB established by AB 813 is significantly different than previous programs. AB 813 requires that the CDHS must implement prepayment utilization controls such as a prior authorization process and may establish post-payment audits to review claims paid under the EDB. This process is available in cases where the pharmacy has attempted to obtain coverage under the Medicare Part D program and has failed due to the circumstances noted in AB 813.

For dates of service beginning May 17, 2006, claims may no longer be submitted under this program using a Code 1 restriction indicator. Instead, to use this program, a pharmacy provider must submit a paper *Treatment Authorization Request* (TAR) to one of the two Medi-Cal Pharmacy Field Offices, explaining the reasons the pharmacy could not be paid by Medicare, and must receive authorization from the State to bill the EDB (see *EDB Prior Authorization Process* below). This bulletin provides the guidelines and processes the pharmacy provider must follow to submit a prior authorization request and claim to the EDB for payment.

Pharmacy providers who encounter problems with a Medicare drug plan should contact the Centers for Medicare & Medicaid Services (CMS), Region IX, for assistance in problem resolution via the following telephone numbers:

(415) 744-3617 – Part D questions about Medicare Advantage Prescription Drug (MA-PD) plans

(415) 744-3628 – Part D questions about Prescription Drug Plans (PDP)

This telephone contact is not necessary in order to use the State program, but is a means to ensure resolution of ongoing problems with the Medicare Part D program.

**** IMPORTANT ****

Pharmacy provider interactions with the PDP/MA-PD, Medicare, a physician or other party may be by telephone, fax or other modes of electronic communication. To receive authorization to use the EDB, a pharmacy must submit a TAR, accompanied by a completed "*California Emergency Drug Benefit for the Dual Eligible - TAR Attachment*" form. The specific actions taken by the pharmacy provider in attempting to obtain Medicare authorization must be checked on the form (Sections A, B, C, or D, as appropriate, and the completed form must be submitted with the TAR. In addition, the pharmacy provider must document any conversations and retain such documentation and documentation of any other forms of communication for future CDHS auditing purposes. Documentation should include persons' and/or organizations' names, dates, times and contact information for all cases.

The sections below include information about the following areas:

- CIRCUMSTANCES COVERED BY THE EDB
- CIRCUMSTANCES NOT COVERED BY THE EDB
- EDB PRIOR AUTHORIZATION PROCESS
- EDB CLAIMING PROCESS

CIRCUMSTANCES COVERED BY THE EDB

The following is a list of circumstances covered by the EDB. Providers must perform the actions listed and provide attestations[1] when submitting a *Treatment Authorization Request* (TAR) (see *EDB Prior Authorization Process*). If the required information is not supplied on the attachment that must be submitted with the TAR, the TAR will be denied or deferred. A TAR will only be deferred once. If the TAR is resubmitted without the required attachment completed, the TAR will be denied.

1. Medicare System Problems or Errors

   "The pharmacy has submitted a claim for the provision of drug benefits to the full-benefit dual eligible beneficiary's Medicare Drug Plan and the claim has been denied payment due to error by the Medicare Program and the pharmacy has made a good faith effort to resolve the error with the Medicare Drug Plan and the Medicare Program."

   The following steps should resolve the system problems or errors encountered by the pharmacy:

   - Take the appropriate steps (e.g., prior authorization or an exception request) required and as directed by the PDP/MA-PD to appropriately bill and receive payment for the drug.
   - Contact the PDP/MA-PD to determine why the claim was denied.
   - If the error is attributable to Medicare and not the PDP/MA-PD (and the PDP/MA-PD cannot resolve the problem) pharmacies are requested to contact CMS at the numbers listed above to request resolution of the ongoing problem.

   If the pharmacy provider is unable to reach resolution of the issue after complying with the requirements/directions provided by the PDP/MA-PD and the pharmacy provider has made a good faith effort to resolve the error, the pharmacy provider may submit a TAR to the CDHS by following the *EDB Prior Authorization Process* outlined below. *Note: The existence of a denial in and of itself does not constitute a legitimate reason to bill the EDB.*

2. Eligibility/Enrollment Problems

   "The pharmacy is unable to submit a claim for the provision of drug benefits solely due to incomplete or inaccurate Medicare Drug Plan enrollment information from the full-benefit dual eligible beneficiary's Medicare Drug Plan, the federal Centers for Medicare and Medicaid Services, or entities under contract with the Centers for Medicare and Medicaid Services to provide enrollment information, and the pharmacy has attempted to resolve these problems with the Medicare facilitated enrollment contractor and the Medicare Drug Plan, where appropriate."

   A Medicare beneficiary may not have adequate proof of enrollment when presenting a prescription to the pharmacy provider. If a beneficiary presents without adequate proof of enrollment (i.e., a plan coverage card or letter showing PDP/MA-PD enrollment information) the pharmacy provider can resolve the problem by clarifying the enrollment status of the beneficiary or by enrolling the beneficiary using the tools provided by CMS. The steps and tools available to resolve this issue are:

   - An Eligibility or E1 online transaction should identify the beneficiary's PDP/MA-PD.

[1] Pharmacy interactions with the Medicare Part D drug plan, Medicare, a physician or other party can be by phone, fax or other modes of electronic communication. The pharmacy must document any conversations and retain it and any other forms of communication for future auditing purposes. Documentation requirements are noted herein.

- A telephone inquiry to 1-800-MEDICARE (1-800-633-4227) should be made to identify the beneficiary's PDP/MA-PD if the E1 transaction does not identify the beneficiary's plan.
- The PDP/MA-PD identified through the above inquires is to be contacted for the beneficiary specific information needed to bill the PDP/MA-PD. The above inquiries may identify more than one plan.**
- If the eligibility transaction does not show enrollment in a Medicare drug plan, and/or the pharmacy cannot get the information from Medicare, and the pharmacy has evidence of full dual eligibility, the pharmacy provider can bill the CMS Wellpoint/Anthem POS (Part D Facilitated Enrollment) system. Instructions and a payer sheet for the Wellpoint/Anthem POS system can be found on the CMS Web site: **Wellpoint/Anthem POS Facilitated Enrollment Instructions** and **Wellpoint/Anthem Facilitated Enrollment Payer Sheet**.

After the pharmacy provider has attempted to identify the plan and the plan's beneficiary specific information or to bill the CMS Wellpoint/Anthem POS (Part D Facilitated Enrollment) system as noted but is unable to due to the failure of the systems above, the pharmacy provider may submit a TAR to the CDHS by following the *EDB Prior Authorization Process* outlined below.

** (*Note*: *If more than one PDP/MA-PD is identified through the above inquires, and each of the plans identified deny that the beneficiary is enrolled in that plan, the pharmacy may submit a TAR to the CDHS).*

3. Co-payment Problems

"The Medicare Drug Plan provides information that the full-benefit dual eligible beneficiary's deductible or co-payment amount is higher than the co-payment amounts that are established by Medicare for full-benefit dual eligible beneficiaries."

In some instances, a PDP/MA-PD may not have information that the beneficiary is a dual eligible. In these instances a co-payment greater than $5 may be indicated by the PDP/MA-PD. In other cases, Medicare may have the incorrect co-payment amount for a person in a nursing facility. CMS has instructed plans to adjust co-pays on evidence of subsidy eligibility and/or dual status.

The following steps should resolve the co-payment problems encountered by the pharmacy provider:

- Verify that the excess co-pay is not a result of a drug's non-formulary status. In some cases, the full price of a non-formulary drug may be returned as the "Part D co-pay."
- Verify that the individual is enrolled in a PDP or MA-PD.
- *Telephone numbers of the pharmacy technical assistance centers for plans in which dual eligibles are being auto-enrolled during 2006 is provided on Page 6 of this document.*
  (**Note:** If the beneficiary has chosen an enhanced plan, the beneficiary may be responsible for premium payments over the benchmark amount, but is not responsible for higher co-payments and/or deductible amounts unless the drug is a Part D excluded drug; if the drug is an excluded drug, pharmacy providers should follow normal Medi-Cal claims rules for secondary payment of these co-pays.)
- If the beneficiary is in a PDP or an MA-PD, contact the PDP or MA-PD and attempt to have the co-payment amount adjusted by providing evidence that the person is a dual eligible.

The Centers for Medicare & Medicaid Services (CMS) has released additional guidance to PDP/MA-PD plans regarding co-payments for patients in nursing facilities.

After the pharmacy provider validates that the co-payment amount is in error and has made a good faith effort to resolve the error with the PDP/MA-PD without success, the pharmacy provider may submit a TAR to one of the two CDHS Medi-Cal Pharmacy Field Offices for approval to bill the EDB for the amount of the co-payment that exceeds what would normally be required from the beneficiary. (See *EDB Prior Authorization Process* and *EDB Claiming Process* below.)

4. Prior Authorization/Exceptions Process Problems
   "Request for prior authorization or exception to the full-benefit dual eligible beneficiary's Medicare Drug Plan is required and was sought by the pharmacist, but the pharmacy does not receive a response within 24 hours for an emergency drug or within 72 hours for a non-emergency drug. When submitting a request for prior authorization to the department, a pharmacy shall show proof of the submission of the request that was made to either the Medicare Drug Plan or the beneficiary's prescribing physician."

   "Beginning September 1, 2006, the department shall not cover drug benefits when prior authorization or exception to the full-benefit dual eligible beneficiary's Medicare Drug Plan is required, unless that authorization was sought by the physician and the Medicare Drug Plan does not provide a response within 24 hours for an emergency drug or within 72 hours for a non-emergency drug."

   A beneficiary's PDP/MA-PD may require prior authorization (formulary drug) or an exception request (non-formulary drug) for a specific drug. In most situations, the PDP/MA-PD requires the beneficiary's physician to submit the request. To provide for prompt adjudication of a prior authorization or exception request by the PDP/MA-PD, the pharmacy can assist by:

   - Immediately notifying the physician of the need for him or her to submit a prior authorization or an exception request to the Medicare drug plan and to provide a copy of that submission to the pharmacy.
   - Providing as much information as available to the pharmacy to assist the physician in seeking prior authorization (see item 5 *Prior Authorization* below).
   - Verifying with the physician whether the drug, in the physician's judgment, is an "emergency" or a "non-emergency" situation to establish which PDP/MA-PD adjudication timeline is applicable.

   Prior to September 1, 2006: If after 24 hours (for an emergency drug) or 72 hours (for a non-emergency drug) the *beneficiary's physician or the Medicare plan does not contact the pharmacy* with a decision by the PDP/MA-PD, the pharmacy provider may submit a TAR to the CDHS. The pharmacy must continue to contact the physician or Medicare drug plan to obtain authorization for future prescriptions.

   Beginning September 1, 2006: If the *Medicare plan has not contacted the physician with a decision* within 24 hours (for an emergency drug) or 72 hours (for a non-emergency drug) *after the physician has submitted a request for authorization*, the pharmacy provider may submit a TAR to the CDHS. The pharmacy must continue to contact the physician or Medicare drug plan to obtain authorization for future prescriptions.

   Both before and after September 1, 2006, pharmacies may dispense a short-term (3-day) or routine (30-day) supply of medications at the time that the beneficiary presents at the pharmacy and bill the EDB for these drugs on a retroactive basis if the conditions specified in this bulletin are met.

CIRCUMSTANCES NOT COVERED BY THE EDB

There are instances when claims are denied by the PDP, and coverage of the drug is not available through the EDB.

1. Excluded Drugs
   These drugs should continue to be billed to Medi-Cal as they were prior to January 1, 2006. The pharmacy provider must verify that the drug they are trying to bill to the PDP is not excluded from Part D. Drugs excluded from Part D must continue to be billed to Medi-Cal and not to the PDP/MA-PD or the EDB. The categories of excluded drugs that Medi-Cal continues to cover are:

   - Anorexia, weight loss or weight gain
   - Symptomatic relief of coughs and colds
   - Non-prescription drugs (Part D, not Medi-Cal, covers insulin and syringes)
   - Barbiturates
   - Benzodiazepines
   - Prescription vitamins and minerals (Select single vitamins and minerals pursuant to prior authorization or utilization restrictions. Combination vitamin and mineral products are not a benefit. Vitamins or minerals used for dietary supplementation are not a benefit.)

Additional information on excluded drugs can be found on the Medi-Cal Web site: **www.medi-cal.ca.gov**. Pharmacy providers should only submit a TAR for an excluded drug if it is not on the *Medi-Cal List of Contract Drugs* or if the prescription exceeds Medi-Cal established utilization controls.

2. Pharmacy Provider Errors
Claims submitted by the pharmacy provider to the PDP that exceed the PDP's established utilization control guidelines are **not** considered errors by the PDP or Medicare. For example, if the pharmacy provider bills greater than a 30-day supply when only a 30-day supply is allowed by the PDP. In these instances, the pharmacy provider must comply with the PDP requirements and processes (such as prior authorization) and may not bill the EDB.

3. Inadequate Reimbursement
The lack of adequate payment (i.e., reimbursement lower than pharmacy provider's cost) is not a legitimate reason to bill the EDB. These issues must be worked out between the provider and the PDP.

4. Standard Medicare Co-payment
The pharmacy provider must never bill the dual eligible co-payment ($1 to $5) to the EDB. This is a standard design of the Medicare drug program and the beneficiary is responsible for this cost sharing. This includes nursing facility patients who may have a $0 co-payment. (See *Co-payment Problems* above)

5. Prior Authorization

A denial due to prior authorization or non-formulary status, alone, is not a legitimate reason to bill the EDB. The pharmacy provider should assist the beneficiary's physician and/or the beneficiary to provide the information needed by the plan to process a prior authorization or exception request.

A sample coverage determination form that many plans will accept, developed by the American Medical Association and the Association of Health Insurance Plans, is posted online at: **www.cms.hhs.gov/MLNProducts/Downloads/Form_Exceptions_final.pdf**.

Denial by a plan of a prior authorization or exception request is a statement by the plan that medical necessity does not exist and the pharmacy provider may not submit the claim to the EDB. In those instances, the pharmacy provider should work with the beneficiary's physician to find an alternative therapy or to provide more information to establish the medical need.

Lack of action on a prior authorization or exception is covered under *Prior Authorization/Exceptions Process Problems* above.

6. Drugs Denied for Safety/Misuse Concerns
Drugs denied due to drug utilization review shall not be billed to the EDB. The CDHS no longer has a complete drug profile on dual eligibles and therefore has to trust the drug utilization review tools employed by the Part D plans. Pharmacy providers must work with the plan and the beneficiary's physician to address these safety/misuse issues.

7. Transitional Coverage from Acute Care
For newly enrolled beneficiaries or beneficiaries being discharged from acute care, the pharmacy provider must access the PDP transitional coverage of drugs or other plan processes to get the drugs covered. The CMS has indicated that the PDP will accept prior authorization requests and coordination from acute hospital discharge planners. Pharmacy providers should work with the discharge planner to ensure that a smooth transition occurs. For any problems in this area, contact the Centers for Medicare & Medicaid Services Region IX staff at:

MA-PD plans – (415) 744-3617

PDP plans – (415) 744-3628

Contact Information for Prescription Drug Plans with Auto-Enrolled Dual Eligibles

2007 Prescription Drug Plan	CMS Contract #	Pharmacy Technical Assistance Line	Operated by:
AARP MedicareRx Plan - Saver	S5921	1-800-797-9794	Prescription Solutions
Advantage Star Plan by RxAmerica	S5644	1-877-279-0372	
Blue Cross MedicareRx Value	S5596	1-866-630-3820	Anthem Prescriptions
Bravo Rx II	S5998	1-800-922-1557	Medco
CIGNATURE Rx Value Plan	S5617	1-800-558-9363	CIGNA
Health Net Orange Option 1	S5678	1-800-693-8951	Argus
HealthSpring Prescription Drug Plan	S5932	1-800-971-1581	HealthSpring
Humana PDP Standard	S5884	1-800-865-8715	Humana
Medicare Rx Rewards Value	S5960	1-866-841-8953	Wellpoint NextRx
Prescription Pathways Bronze	S5597	1-800-311-0557	Prescription Pathways
Sierra Rx/Sierra Rx Basic	S5917	1-800 443-8197	Sierra Rx
WellCare Classic/WellCare Signature	S5967	1-866-800-6111	

EDB PRIOR AUTHORIZATION PROCESS

The CDHS has established a prior authorization process to review the need for a medication before a claim is submitted to the EDB for reimbursement. Pharmacy providers must follow these guidelines regarding TAR submission and documentation requirements. The CDHS has developed a **Medicare Part D Drug Emergency Access** form, entitled *"California Emergency Drug Benefit for the Dual Eligible – TAR Attachment,"* to assist pharmacy providers in documenting the steps taken prior to submission of the TAR. A sample form and instructions for completing it are attached to this bulletin.

- Pharmacy providers must submit a TAR using the *50-1 or 50-2 Treatment Authorization Request* forms with a copy of the *California Emergency Drug Benefit for the Dual Eligible – TAR Attachment* form attached.
- TARs must be faxed or mailed to the appropriate Northern or Southern Medi-Cal Pharmacy Field Office.

  NOTE: Electronic TAR submission is not allowed under the EDB.
- The pharmacy provider must note on a *California Emergency Drug Benefit for the Dual Eligible – TAR Attachment* form the steps taken to resolve the problem.
- For drugs that would normally require prior authorization in the Medi-Cal program (i.e., drugs that are not on, or that exceed the restrictions of, the *Medi-Cal List of Contract Drugs*), the pharmacy provider must document the medical necessity.
- In addition to the diagnosis, the pharmacy provider must indicate "Part D Emergency TAR" in the *Diagnosis Description* section of the TAR and enter the code "R48" in the *Service Category* field at the top of the TAR. Doing so enables the CDHS to appropriately track and handle these TAR requests.
- *Units of Service* requested must be "1". The CDHS will not approve multiple refills through this process.
- The quantity of medication requested must not be greater than the amount the beneficiary's PDP/MA-PD will allow for a single dispensing. For example, if the PDP only allows for 30 tablets of a specific drug, the TAR request must be for a quantity of 30 or less. If the unresolved problem is due to a prior authorization or exception request related to a quantity override, the pharmacy may enter the quantity being requested from the PDP/MA-PD.

EDB CLAIMING PROCESS

- Pharmacy providers are to submit claims in the same way they submit other prescription drug claims to Medi-Cal**.** *If the claim is for a dual eligible who has met their Medi-Cal Share of Cost in at least one month in 2005 or 2006 and as a result is eligible for Part D, the provider must submit the claim on paper via a Pharmacy Claim Form (30-1).*
- Because the process now requires a TAR, pharmacy providers should not indicate that the Code I restriction has been met.
- Pharmacy providers are reminded to include the TAR number on the claim or the claim will be denied.
- For claims where Medicare has set the co-payment amount to be greater than that for dual-eligible beneficiaries ($1 to $5), the pharmacy provider must submit an "other coverage" claim. The amount-billed field must contain the pharmacy provider's usual and customary charge for the prescription and the other-coverage-paid field must contain the amount that the Medicare program is reimbursing the pharmacy provider, plus the normal co-payment due from the patient. This is the same method used for all Medi-Cal claims for beneficiaries who have other coverage.
- Claims will be reimbursed based on the rates established for the Medi-Cal program.

California Emergency Drug Benefit for the Dual Eligible
TAR attachment (revised November 3, 2006)

Instructions:

1. Enter the *Beneficiary Name* (Last, First, M.I.). The name must match the name on the TAR form (50-1 or 50-2).

2. Enter the beneficiary's *Medi-Cal Identification number*. The number must match the number on the TAR.

3. Enter the TAR control number from the TAR.

4. Select only one of the four sections that best describes the circumstance requiring coverage under the EDB program.

5. Check or fill-in only the actions actually performed by the pharmacy provider. In the "Date" field, use MM/DD/YYYY. In the "Time" field, use a 24-hour clock (i.e., 0900, **not** 9:00 am).

6. Send the form as an attachment with the TAR via fax or by mail.

EXAMPLE (September 1, 2006 and later)

The pharmacy provider finds that a drug needs prior authorization approval from the Part D plan. The pharmacist contacts the physician and informs him/her of this fact and provides pertinent information for the physician to use in seeking prior authorization. The pharmacy provider ascertains from the physician that the drug does not need to start right away (i.e., it is a non-emergency drug). After 72 hours, the pharmacy provider confirms with the physician that the prior authorization has been approved or denied by the plan.

The pharmacy provider may then submit a TAR. In this instance, because the reason is a prior authorization issue, the pharmacy provider would fill out Section D as follows:

D. Prior Authorization/Exceptions Process Problems

The following steps were taken to obtain prior authorization in a timely manner.

1. Confirmed that **the prescriber has contacted the plan** regarding the need for a prior authorization or an exception request. X

   Date: 9/1/2006 Time: 1100

2. Confirmed that **the prescriber has not received a response from the plan** regarding the prior authorization or exception request. X

   Date: 9/4/2006 Time: 1200

3. Verified with the prescriber the "emergency"/"non-emergency" status of the drug. X

   Check one: Emergency _____ Non-Emergency X

California Emergency Drug Benefit for the Dual Eligible
TAR attachment (revised November 3, 2006)

Beneficiary Name (Last, First, M.I.)	Medi-Cal Identification Number	TAR CONTROL NUMBER - -

A. Medicare System Errors
The following steps were taken to resolve system errors with the beneficiary's PDP/MA-PD or with Medicare:

1. PDP/MA-PD contacted to determine why the claim was denied. _____
2. Pharmacy took actions required/directed by the PDP/MA-PD. _____
3. Medicare was contacted to resolve the problem, if error is attributable to Medicare. _____

B. Eligibility / Enrollment Problems
The following steps were taken to resolve problems regarding the beneficiary's eligibility/enrollment:

1. An Eligibility or E1 online transaction. _____
2. A telephone inquiry to 1-800-MEDICARE. _____
3. The PDP/MA-PD contacted for the beneficiary billing information. _____
4. Attempted unsuccessfully to bill the CMS Wellpoint/Anthem POS Part D Facilitated Enrollment system after establishing evidence of full dual status, absence of Part D enrollment, and after calling the Wellpoint Pharmacy Technical Assistance Help Desk at 1-800- 662-0210 to resolve any billing issues. _____

C. Co-Payment Problems
The following steps were taken to resolve co-payments and/or deductible amounts higher than those established for full-benefit dual eligible beneficiaries.

1. Verified that the beneficiary's excess co-pay is not a result of a drug's non-formulary status. _____
2. Contacted the PDP/MA-PD and requested the co-payment amount be adjusted and provided evidence of subsidy/dual status. _____

D. Prior Authorization/Exceptions Process Problems
The following steps were taken to obtain prior authorization in a timely manner.

1. Confirmed that **the prescriber has contacted the plan** regarding the need for a prior authorization or an exception request. _____

   Date: _____ Time:_____

2. Confirmed that **the prescriber has not received a response from the plan** regarding the prior authorization or exception request. _____

   Date: _____ Time:_____

3. Verified with the prescriber the "emergency"/"non-emergency" status of the drug. _____

   Check one: Emergency _____ Non-Emergency _____